The Affordable Care Act and Recent Reforms: Policy Implications for Equitable Mental Health Care Delivery

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Abstract: Controversy exists over how to ethically distribute health care resources and which factors should determine access to health care services. Although the US has traditionally used a market-based private insurance model that does not ensure universal coverage, the Patient Protection and Affordable Care Act (ACA) in the United States aims to increase equitable access to health care by increasing the accessibility, affordability, and quality of health care services. This article evaluates the impact of the ACA on equitable mental health care delivery according to access factors that can hinder or facilitate the delivery of mental health services based on need. The ACA has successfully expanded coverage to millions of Americans and promoted coordination and access to mental health care; however, financial and non-financial access barriers to mental health care and access disparities remain. Reform efforts should not undervalue the gains that the ACA has made but should attempt to balance considerations of cost and increasing free-market mechanisms with decreasing remaining health care disparities.

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The impact of the Affordable Care Act on appropriate mental health care delivery in the United States

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List of Abbreviations

ACO	Accountable Care Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
IT	Information Technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
MHPAEA	Mental Health Parity and Addiction Equity Act
PCMHs	Patient Centered Medical Homes
ACA	Patient Protection and Affordability Care Act
SDM	Shared decision-making
US	United States
WHO	World Health Organization

Abstract

Mental illness constitutes a large worldwide disease burden that must be addressed through access to comprehensive, high quality mental health care. The Patient Protection and Affordability Care Act (ACA) aims to increase accessibility, affordability,

and quality of health care services and has the potential to support appropriate mental health care delivery. We used the appropriate care framework to assess the impact of relevant ACA policy on mental health care delivery from the financial, clinical and individual patient perspectives using secondary sources and gray literature. We found that the ACA has successfully expanded coverage to millions of Americans and promoted coordination and access to mental health care, however financial and non-financial access barriers to appropriate mental health care remain. We caution that reform efforts should not undervalue the gains that the ACA has made, but should attempt to remedy remaining gaps. We suggest that these gaps can be addressed through policy that expands the breadth and depth of mental health care coverage, reduces out of pocket costs through fair competition and appropriate subsidies, incentivizes increased supply of mental health care professionals, utilizes new models to coordinate care, and facilitates community efforts to increase health seeking behavior.

Keywords

Delivery of Health Care; Mental Health; Health Care Reform; Patient Protection and Affordable Care Act

Mental disorders are one of the leading causes of disability worldwide (Whiteford et al., 2013) and are estimated to affect 18% of adults in the United States. (*Any mental illness (AMI) among US adults.*2015) Mental health disorders top the list of the most expensive conditions in the US, accounting for $201 billion in direct health care spending and $467

billion in direct and indirect costs due to lost earnings and public disability insurance payments. (Roehrig, 2016) Despite this high price tag, mental health disorders often go undiagnosed or misdiagnosed. (Boonstra, Wunderink, Sytema, & Wiersma, 2008) Currently, 62% of people with mental illness and 41% of people with serious mental illness in the US do not receive outpatient treatment in the form of medication or psychological care. (Walker, Cummings, Hockenberry, & Druss, 2015) Those suffering from serious mental illness who are most in need of mental health services are disproportionately African American, male, uninsured, and with lower incomes, (McAlpine & Mechanic, 2000) all characteristics that correspond with traditional coverage gaps that exacerbate health disparities. In addition, high rates of emergency department use and inpatient readmissions (Jiang et al., 2016) for individuals with mental health disorders raise concerns that treatment is delivered in inappropriate settings with missed opportunities for preventive care.

Delivering appropriate mental health care ensures that individuals with mental illness receive the right care, at the right cost, delivered in the right way from both the patient and provider perspectives. Appropriate care policies can therefore not only improve access and improve wellbeing for individuals, but also address social inequalities and rising health care costs on a societal level. Mental health care delivery should be financially appropriate, effectively allocating resources to address need and reduce waste; clinically appropriate, providing evidence-based care by qualified mental health providers; and individually appropriate, providing care that responds to individual

clinical and non-clinical needs and is respectful of patient preferences and values. (Robertson-Preidler, Anstey, Biller-Andorno, & Norrish, 2017)

The 2010 Patient Protection and Affordability Care Act (ACA) aims to improve accessibility, affordability, and quality of health care in the US by expanding insurance coverage and required health benefits, increasing competition through insurance marketplace exchanges, and promoting new delivery models that emphasize patient-centered, evidence-based care that could facilitate more appropriate mental health care delivery practices (Obama, 2016). However, given the recent reform debates and elimination of certain key provisions in the law, such as the repeal of the individual mandate and insurance subsidies, it is vital to understand how the ACA affects mental health care delivery and the impact that repeals could have on access to high quality mental health care for individuals suffering from mental health disorders.

This analysis identifies policies in the ACA that are relevant to mental health care delivery and examines current evidence of the impact of this legislation for appropriate mental health care delivery using the appropriate care framework. (Robertson-Preidler et al., 2017) The appropriate care framework provides a comprehensive approach to identifying health systems policies that impact health care delivery based on Sanmartin's perspectives of appropriateness that include the financial perspective that focuses on allocating health care resources in a just way, the clinical perspective that focuses on delivering clinically effective care, and individual perspective that focuses on

responding to individual needs and preferences (Figure 1). (Robertson-Preidler et al., 2017; Sanmartin et al., 2008) Policies that impact mental health care delivery were identified through a thorough reading of the ACA law and the impact of each provision was assessed using secondary sources, peer-reviewed articles, and gray literature, including data and reports from national health systems and organizations. After identifying relevant provisions and the impact of these provisions, we discuss remaining gaps and make policy recommendations for addressing these gaps from the financial, clinical, and individual perspectives (Table 1).

Financial appropriateness: Promoting access and reducing waste. To prevent both overuse and underuse of mental health care, policy efforts must seek to ensure access to necessary mental health care services while reducing waste and decreasing unnecessary care. For mental health care, this requires providing access to primary and specialty treatment to prevent the occurrence of more severe and expensive acute care through comprehensive insurance coverage for mental health care, low out-of-pocket costs, and incentives for mental health providers to accept patients, regardless of the payer.

Expanding insurance coverage. The ACA has promoted financial access to mental health care services by expanding insurance coverage and strengthening parity laws that require insurers to provide equivalent medical and mental health coverage. These reforms have decreased the proportion of uninsured by 43% (Obama, 2016) through

mandated insurance purchase, expanded dependent coverage until age 26, expanded Medicaid eligibility, and prohibited insurance exclusions based on preexisting conditions. The ACA has also promoted more comprehensive mental health care coverage by expanding the scope of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) to include individual and group plans, which must provide equivalent financial requirements (i.e., copayments and deductibles) and treatment limitations (i.e., number of visits or days of coverage) for mental health and substance use benefits as for medical and surgical benefits. (Centers for Medicare and Medicaid Services (CMS), 2017) In addition, public programs and Marketplace Qualified Health Plans offered through the Marketplace health care exchanges are required to include mental health, rehabilitative, habilitative, and preventive services. (US Department of Health and Human Services (HHS), 2014)

Preliminary findings on the impact of expanding coverage in response to ACA indicate increased use of mental health services (Creedon & Cook, 2016) and some improvements in mental health outcomes. (Burns & Wolfe, 2016) However, 14.7% of adults with a mental illness are still uninsured (*Mental health in America- access to care data.*2016) despite an overall decrease in the number of uninsured to 12.5% in 2015, and racial/ethnic disparities in insurance coverage (Novak, Williams-Parry, & Chen, 2016) and mental health service use (Creedon & Cook, 2016) remain.

Certain legal restrictions and glitches within the law have hindered universal coverage, especially for the working poor. The Supreme Court ruling against mandatory Medicaid expansion led to 19 states opting not to expand Medicaid, which has left a coverage gap between those who qualify for traditional Medicaid and those who can afford private insurance premiums. Furthermore, some individuals may opt not to purchase insurance because they do not earn sufficient income to receive tax penalties, even though they may qualify for subsidies that would decrease their out-of-pocket premiums. Even those with health care coverage often lack comprehensive mental health benefits, (National Alliance on Mental Illness (NAMI), 2015) and the scope of coverage differs by payer. Marketplace Qualified Health Plans and expanded Medicaid plans that must include mental health service coverage equal in scope to those provided by a typical employer-sponsored plan exclude many important mental health services, such as opioid treatment, residential care, case management, crisis intervention, and supportive social services. (Garfield, Lave, & Donohue, 2010) Low insurance acceptance rates by psychiatrists, especially for Medicaid, is also an important issue that needs to be addressed. (Bishop, Press, Keyhani, & Pincus, 2014)

To ensure health care is affordable for high cost patients, such as individuals suffering from mental disorders, the ACA prohibits insurers from denying coverage based on preexisting conditions or basing premiums on patient risk. To decrease insurers' incentives for targeting healthy patients and avoiding sicker ones to save costs, the ACA regulates Marketplace plan competition through the risk adjustment, reinsurance, and

risk corridor programs. These programs aim to decrease risk selection by calculating the average patient risk for each insurance plan and transferring costs from low risk plans to high risk plans. However, risk adjustment and parity coverage requirements have not been sufficient to eliminate risk selection and incentives still remain for insurance companies to use distorted network to attract low risk patients and deter high risk patients such as individuals with mental health disorders. Although many insurance plans meet mental health coverage criteria, in practice network designs can limit access through limited availability of certain specialties and services, more stringent medical necessity criteria for mental health coverage, and high cost sharing for prescription drug costs. (Montz et al., 2016) In addition, some health care plans, even within the Marketplace, may not be meeting parity requirements; however a patchwork system of accountability undermines enforcement (Goodell, 2015).

Reducing costs for patients. Out-of-pocket costs are another barrier to mental health care access, contributing to between 25% to 50% of unmet mental health care need. (Substance Abuse and Mental Health Services Administration (SAMHSA), 2012) To address cost concerns for individuals buying insurance on the marketplace, the ACA provides premium subsidies for low-income individuals. However, a provision in the law known as the "family glitch" prevents family members from qualifying for premium subsidies if one family member has "affordable" employer-based coverage, making coverage unaffordable for some families. Although Marketplace plan deductibles may not exceed $10,000 (USD) per year, 46% of plans have deductibles above $2,500 per

year, compared to only 21% of all private insurance plans. (National Alliance on Mental Illness (NAMI), 2015) In addition, some out-of-pocket costs for prescriptions and outpatient services are higher in Marketplace plans compared to private insurance plans. (National Alliance on Mental Illness (NAMI), 2015)

Clinical appropriateness: Providing evidence-based care. Evidence-based clinical care in the US is compromised by a limited number of qualified mental health care providers, fragmented delivery systems, and inadequate quality monitoring practices and information technology (IT) infrastructure. Rising rates of prescription medication use that may not be evidence-based and inadequate rates of psychosocial care raise concerns that care is not clinically appropriate. (Substance Abuse and Mental Health Services Administration (SAMHSA), 2012) Furthermore, sociodemographic disparities in medication use (Han & Liu, 2005) and access to psychotherapy (Chen & Rizzo, 2010) indicate barriers to clinically appropriate treatment.

The ACA promotes the use of new delivery models, including Accountable Care Organizations (ACOs) and medical homes that provide incentives to integrate and coordinate health care services, including mental health care. Preliminary outcomes from Medicare and Medicaid demonstration projects and private pilot programs suggest some positive trends in performance, though evidence has been mixed and evaluation efforts have been incomplete and challenged by variation in model and organization. (Mechanic & Olfson, 2016)

ACOs are networks of providers that share savings with payers (e.g., Medicare) when certain quality measures are met and therefore may have an incentive to integrate and coordinate mental health care to save costs and improve outcomes. However, studies have found that most ACOs continue to pursue fragmented medical and mental health care delivery (Lewis et al., 2014) and some ACO demonstration projects did not find an improvement in cost or mental health outcomes compared with outcomes from non-ACO providers. (Busch, Huskamp, & McWilliams, 2016) In a study of 90 ACOs, Fullerton and colleagues (2016) found a lack of behavioral health providers, data availability, and sustainable funding as barriers to mental health care coordination and outcome improvement. (Fullerton, Henke, Crable, Hohlbauch, & Cummings, 2016)

Medical home models, such as Patient Centered Medical Homes (PCMHs) and Health Homes (for those with serious mental illness or with more than one chronic condition) are specifically designed to manage chronic illness and complex medical care by coordinating patient care through a primary provider. (Druss & Mauer, 2010) Studies have found that having a usual provider increases the likelihood of receiving mental health services and patients who have a usual provider in medical homes are more likely to receive mental health counseling (Jones et al., 2015) and improved access and care coordination. (Kleiman, Hayes, & Churchouse, 2016) While more work is needed, medical homes hold potential for promoting appropriate mental health care.

Quality metrics and information technology systems can provide real-time information and feedback to help clinicians make clinically appropriate decisions and avoid unnecessary utilization. This information architecture is needed to support new delivery models and evidence-based practice; however quality measures and information technology systems are more limited for treating mental illness than conditions in general health care. (Kilbourne, Keyser, & Pincus, 2010) Specifically for mental health, the ACA includes quality metrics for depression screening and follow-up for ACOs, Medicare beneficiaries, and adults in Medicaid; antidepressant management and 7-day follow-up after hospitalization for mental illness in Qualified Health Plans; quality standards and incentives for integrating mental health care in PCMHs; (Centers for Medicare and Medicaid Services (CMS), 2016) and incentives for hospitals to reduce ambulatory sensitive admissions, which are often closely tied with mental illness. (Bartels, Gill, & Naslund, 2015) For psychiatric hospitals, the ACA requires enhanced outcome reporting and supports a pilot project for value-based purchasing that rewards psychiatric hospitals that meet specific performance standards. (Bartels et al., 2015)

However, current performance measures have been criticized for being inadequate for assessing quality mental heath care delivery and creating perverse incentives for providing inappropriate treatment. The depression screening quality metric in ACOs has resulted in 79% of ACOs in the Medicare Shared Savings Program in 2013 meeting the minimum depression benchmarks. (Abrams et al., 2015) However, depression screening measures have drawn criticism for both encouraging providers to overdiagnose

depression and for not being comprehensive enough to measure appropriate follow-up care or mental health outcomes. (Mojtabai, 2017)

To promote the uptake of health information technology (HIT), the ACA requires medical home demonstration projects to include HIT systems because of their vital role in tracking patient information, prescribing, and providing tools for evidence-based decision-making. (Druss & Mauer, 2010) However, effective implementation of new information systems requires additional investment in IT infrastructure and technical assistance. The need for high financial investment, especially for solo practices, and concerns about stigma and privacy security thwarts the use of HIT in behavioral health. (McGregor et al., 2015) Access to information about hospital admissions and discharges and emergency department visits in real-time could provide primary care providers with data necessary to quickly follow-up with timely and necessary care, few organizations have systems in place to provide these real-time data.

Individual appropriateness: Responding to patient clinical and non-clinical needs and values. Last but not least, individuals with mental health disorders may not receive the services they need because they have not been diagnosed, do not seek care or are not engaged in their care in the clinical setting. Beyond financial barriers, patients with mental illness often do not seek mental health services because they do not perceive the need for treatment, they believe they can solve their issues on their own or that their symptoms will improve over time, or because they fear stigma related to mental

illness. (Mojtabai et al., 2011) Although the ACA does not specifically address barriers to health seeking behavior, it includes provisions for monitoring access and treatment disparities that may indicate barriers to mental health care seeking. It also promotes the use of community health workers that help assess needs at the community level and are shown to increase access to services, especially for the underserved. (Swider, 2002)

Promoting patient engagement and shared decision-making. Even when patients access mental health services, they may not receive the care that meets their specific clinical and non-clinical needs. Patient participation in mental health decision-making is a vital to align patient values and preferences and empower patients to follow-through with treatment plans. (Tambuyzer & Van Audenhove, 2015)

The ACA provides funding for an independent entity to develop patient decision aids for federal programs and authorizes the Center for Medicare and Medicaid Innovation to test shared decision-making models, however progress on these provisions has been slow. (Oshima Lee & Emanuel, 2013) In addition, the ACA requires patient experience monitoring for Qualified Health Plans and public delivery model demonstration projects using CAHPS patient surveys that include measures for shared decision-making, provider communication, health promotion and education, and patient rating of provider. (Centers for Medicare and Medicaid Services (CMS), 2016) The Law also provides grants for training health professionals in communication and cultural capacity. To further promote shared-decision making implementation, additional investment in provider

training, information systems that supports access to evidence and information sharing, non-physician clinician team members, and provider incentives for use are needed. (Drake, Cimpean, & Torrey, 2009; Friedberg, Van Busum, Wexler, Bowen, & Schneider, 2013)

New reforms and potential impacts

Although comprehensive reform efforts to repeal the ACA have not been successful, elemental provisions of the law have been effectively repealed, such as the individual mandate that required individuals to buy insurance or face a tax penalty and subsides for cost sharing reduction payments that reduce deductibles and co-payments for low income individuals. The Congressional Budget Office estimates that repealing the individual mandate would reduce federal deficits by about $338 billion; however it is also projected to increase the number of uninsured by 13 million by 2027 and raise premiums in the non-group market by 10 percent (Congressional Budget Office, Nov 2017) . Furthermore, ending federal subsidies of the cost-sharing reduction payments has led most insurance companies to raise premiums for these plans by about 10 percent in 2018 to pay for these cost sharing reductions that they are required to provide (Congressional Budget Office, 2018) . These policy reforms have had the effect of decreasing federal spending, but increasing financial pressure and financial access barriers for appropriate mental health care to patients.

In addition, Medicaid work requirement waivers have been approved in four states, including Arkansas, Indiana, Kentucky, and New Hampshire, and are pending in 7 other states (Henry J. Kaiser Family Foundation (KFF), 2018). This comes after the Trump Administration said it would allow such work requirements to qualify for Medicaid and CMS issued guidance on work requirement waiver applications in January 2018. The purpose of these waivers is to incentivize able bodied individuals on Medicaid to work to force beneficiaries to contribute, help lift people out of poverty, and decrease the overall Medicaid spending. However, opponents question the practical consequences of such requirements. A study of Michigan's recipients of expanded Medicaid found that about half of recipients are employed and of those who are not employed half are either care givers, students, retired, are physically unable to work (Tipirneni, Goold, & Ayanian, 2018) . The majority of remaining unemployed were older and/ or suffered from chronic mental or physical conditions that could prevent them from working (Tipirneni et al., 2018) . Furthermore, monitoring work criteria could be difficult and expensive and working recipients could be penalized given the emerging gig economy with flexible and unstable working hours (Cross-Call, 2018).

Policy recommendations

The ACA has the potential to promote appropriate mental health care through insurance expansion, promotion of new delivery models that incentivize coordinating and integrating mental and medical care, and provisions to increase quality monitoring and patient involvement in care. However, gaps in the law, flexibility in delivery model

design, certain legal limits (i.e., Supreme Court ruling against mandatory Medicaid expansion), recent reforms aimed to dismantle key provisions of the law, and real-world complexities have sometimes thwarted implementation efforts and impacted outcomes.

In terms of fair allocation policies for mental health care, the ACA seeks to provide financial protections through expanded insurance coverage and strengthened parity policies that include more comprehensive mental health care benefits. Medicaid expansion has especially helped to provide access to mental health care for vulnerable populations, such as single males living below the poverty line that are disproportionately affected by mental illness. (Creedon & Cook, 2016; McAlpine & Mechanic, 2000) However, coverage gaps remain and are predicted to increase after the individual mandate is no longer enforceable and states continue to add Medicaid work requirements. Currently, nearly a third of individuals without insurance have mental health or substance use disorders even though an estimated 90% of the uninsured with mental and substance use disorders are eligible for Medicaid or premium subsides. (Ali, Teich, & Mutter, 2017) This indicates structural barriers to getting insurance and further need for education, outreach, and meaningful incentives for obtaining insurance. Even those with insurance coverage are not ensured access to mental health services. Other financial barriers to care, including premiums and out-of-pocket costs, remain high. In additional, non-financial barriers to care, such as limited network designs and a lack of trained mental health care professionals impede individuals from getting the services that they need.

System level appropriateness is shaped by system values and priorities for resource allocation and equity. (Sharpe, 1997) The current health reform debate will determine how the US will define appropriateness in terms of access, investment, and patient rights and obligations. A key debate centers around how to define fair distribution of tax dollars in terms of equity, choice, taxation burden, and who deserves tax-funded health care. Recent reform efforts have sought to reduce federal spending to decrease deficits and potentially reduce tax burdens on US residents. However, these reforms could come at the cost of access to necessary health care and mental health care for those who desperately need it. The addition of many state Medicaid work requirements that aim to decrease Medicaid spending may have more of a moral impetus than a practical one since administrative costs and consequences of reduced coverage could outweigh Medicaid savings. These debates provide an opportunity to address current barriers to appropriate mental health care delivery; however, it is vital that policymakers do not discard the progress that has been made under the law or further exacerbate gaps by limiting coverage or patient protections. Bipartisan reform of the current law is needed to reduce costs, bridge coverage gaps, incentivize providers to provide mental health care, and engage patients.

There has been significant political pushback to ACA provisions over cost and individual liberties concerns. Current reform efforts are pushing for decreased government expenditure on Medicaid and premium subsidies and increased choice for insurance

purchase. However, these proposed policy changes should be weighed against the opportunity costs of limiting mental health care coverage such as increased direct costs of acute care for preventable conditions; higher rates of disability that impacts individuals' ability to work; and sociodemographic health and economic disparities. Decreasing Medicaid coverage now or in the future would only serve to exacerbate mental health disparities that are mostly born by vulnerable populations that cannot afford private health care premiums. New reform efforts should aim to narrow current gaps in coverage and access instead of broaden them. This means ensuring insurance coverage for those who cannot afford private premiums, incentivizing insurance purchase to decrease high risk pools and lower insurance premiums, and decreasing out-of-pocket costs by increasing competition, and regulating insurance markets to ensure that benefits are comprehensive and networks do not incur limits that equate to access constraints.

Beyond insurance reform, cost of health care must be addressed to ultimately decrease costs to the government and patients in the US. Aligning incentives to decrease the underuse and overuse of services is necessary to decrease costs and improve outcomes. This must include incentives for providing evidence-based, integrated, and coordinated care. New health care delivery models, especial medical home models and integrated teams, seem to have the potential to address unmet mental health need and reduce unnecessary care. Effective quality monitoring and feedback processes will be vital to

seize upon the progress being made and make necessary adjustments to accommodate real world complexities and diverse patients populations.

Furthermore, to increase access to necessary preventive and outpatient services, provisions are needed to increase the supply of qualified mental health providers. To incentivize providers to accept more patients, current payment systems that often discourage providers from accepting certain forms of insurance due to time consuming paperwork and low reimbursement rates must be reformed to decrease provider burden. Expanding loan repayment programs for mental health professionals practicing in underserved areas and increasing Medicaid reimbursement rates for treating serious mental illness may help to further address mental health specialty shortages. (Olfson, 2016) Medical school and continuing education curriculum should include mental health education and training to increase the supply of qualified mental health providers in primary care.

Cultural stigma and other non-financial barriers to mental health care seeking by patients must also be addressed through education and public campaigns and increased community engagement. Health education in schools could help build a culture of mental health awareness to decrease stigma and teach pathways to care. Community health workers could help play a vital role in connecting patients to the resources that they need. Investigating and implementing other cultural acceptable pathways into care, such as outreach by faith-based organizations, may help bridge disparities in

access due to culture-specific health seeking behaviors. (Villatoro, Dixon, & Mays, 2016) Furthermore, clinician training in communication and shared decision-making can help engage patients to be stakeholders in treatments and help them attain their self defined quality of life goals.

Framing a balanced approach to mental health care delivery can not only help align stakeholders' goals for system improvement, but can also help develop ethical policies that navigate priorities and tradeoffs in resource constrained systems. (Robertson-Preidler et al., 2017)

Conclusion

The goals of the ACA align with the goals of appropriate care provision in term of providing affordable, accessible, quality care. The ACA has the potential to promote financially appropriate mental health care by increasing financial accessibility through insurance expansion, clinically appropriate care through quality monitoring and new delivery models that incentivize coordinating and integrating mental and medical care, and individually appropriate care by facilitating patient involvement in care. Health care reform debates provide an opportunity to address remaining coverage gaps without undoing the progress that the ACA has made for appropriate mental health care delivery.

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